Special Needs Project Health Survey/Screening
Demonstration Site, County Commission

Child's First Name:	**Child's Last Name:**
Child's Date of Birth:	**Child's gender:** ☐ **Male** ☐ **Female**
Name of person who completed this form: **Is this person a health care provider?** ☐ **Yes** ☐ **No**	**Phone Number:**

1. Date of survey	**2. Program conducting survey (select only one.)** ***This section will be customized to list the programs conducting health screenings..***
(mm/dd/yyyy):	

3. Language used for survey

☐ English ☐ Spanish ☐ Other _____

4. Location of survey (Select only one.)

☐ Family home	☐ Family resource center	☐ Hospital or clinic
☐ Childcare setting	☐ Other community setting	☐ Unknown
☐ Preschool	☐ Early intervention classroom or center	

5. Occupation of person conducting survey (Select only one)

☐ Audiologist	☐ Occupational therapist	☐ Social worker
☐ Child care provider	☐ Optometrist	☐ Special education teacher
☐ Early childhood teacher	☐ Paraprofessional	☐ Speech and language therapist
☐ Early intervention specialist	☐ Physical therapist	☐ Other
☐ Mental health professional	☐ Physician/pediatrician	☐ Unknown
☐ Nurse	☐ Psychologist	

Questions for Parents About General Health Status and Care

6. Was the child born prematurely?

☐ Yes ☐ No If Yes, how many weeks early?

7. Is there a doctor or other health care provider that the child is usually taken to for well-child care? ***(List name if yes)***

☐ Yes ☐ No ☐ Don't know/Declined If yes, what is the name of the doctor or health care provider?

8. When was the child's last visit to the medical provider?	**9. When did the child last see a dentist or dental hygienist for dental care?**
☐ Less than a year ago	☐ Less than a year ago
☐ Between 1 to 2 years ago	☐ Between 1 to 2 years
☐ 2 years ago or more	☐ 2 years ago or more
☐ Never	☐ Never
☐ Don't know/Declined	☐ Don't know/Declined

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Child's First Name:	Child's Last Name:

10. Would you consider the child's health to be:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Health concerns

	No concern/ up-to-date	Concern present	Some concern	Don't know/ declined	Screener concerned: Yes	Screener concerned: No
11. Do you have any concerns about the child's physical health?	☐	☐	☐	☐	☐	☐
12. Do you have any concerns about the child's dental health?	☐	☐	☐	☐	☐	☐
13. Do you have any concerns about the child's nutrition?	☐	☐	☐	☐	☐	☐
14. Do you have any concerns about the child's hearing?	☐	☐	☐	☐	☐	☐
15. Do you have any concerns about the child's vision?	☐	☐	☐	☐	☐	☐
16. Are the child's immunizations up-to-date? *(If incomplete, check box in the "Concern present" column.)*	☐	☐	☐	☐	☐	☐
17. Has the child had any significant health problems in the past? (*Health history includes factors influencing health such as serious or repeated infections, chronic conditions, hospitalizations, surgeries, and medications.)*	☐	☐	☐	☐	☐	☐

18. Were any serious health concerns identified that require further assessment and treatment?

☐ Yes ☐ No ☐ Don't know/Declined

19. List any referrals made based on this screening visit and the purpose of referral.

Referral agency 1:_____	Referral agency 2:_____
Date of referral 1 (mm/dd/yyyy) _____	Date of referral 2 (mm/dd/yyyy) _____
Referral type: ☐ Assessment ☐ Service	Referral type: ☐ Assessment ☐ Service